Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgment before publication.

The Abortion Crisis

TO THE EDITOR: In a six-to-three opinion, the United States Supreme Court recently (June 1977) ruled that the Constitution and the Social Security law do not prevent states from refusing to pay for nontherapeutic abortions for poor women.

We must face reality. In recent years some 1½ to 2 million abortions occur every year in the United States, and no amount of birth control education, free clinics or new techniques have altered this situation.

Thus, from a health viewpoint, poor women must now seek help from backroom abortionists and can end up with problems and either die or be crippled for life—the latter being very expensive to Medicaid, which pays for the care of these ill, at great cost. One very sick patient in intensive care can cost the government $20,000 to $30,000 —enough to pay for 100 to 150 abortions at $200 each.

Before the legalization of pregnancy terminations, illegal abortions constituted the leading cause of maternal deaths. How many there were is purely conjectural, for only since 1974 has accurate reporting for all states been established. As an example, in New York City alone there were reported 25 to 35 criminal abortion deaths in each of the five years immediately preceding 1970. Thus those that occurred throughout the country had to be in the hundreds each year. Taking statistics from the April 1977 issue of *Abortion Surveillance,* published by the United States Department of Health, Education, and Welfare (DHEW), during the year 1975 there were four illegal abortion deaths throughout the country. In 1976 New York state reported there were no such deaths. In an *OB-GYN News Bulletin,* July 1977, Dr. Edelin of Boston cited data from a Georgia study, which he said showed 88 percent of the deaths from illegal abortion in that state were poor black women.

To be more specific regarding economics and costs: the price of an abortion is approximately $200 through Medicaid; the cost of having a baby is about $1,100, unless a cesarean section is done (now some 18 percent of all deliveries[1]), then Medicaid picks up a tab of close to $1,700. This is just the beginning. For the next 18 years there will be problems with these unfortunates. The cost to the public skyrockets to more than $1,000 per year per child, perhaps to $2,000 (more, if the child is abnormal), or an average of some $1,500 per year for 18 years, or $27,000 per nonabortion.

In 1976 Nevada Medicaid spent $80,000 on abortions at approximately $200 per case. This meant about 400 abortions. If these same patients were to have had their babies and were to stay on welfare for 18 years, the cost would be, at $27,000 each, $10,800,000. This is just for Nevada, the 46th state in total population.

Throughout the country an estimated 300,000 women will be left without means of a free abortion, according to DHEW. This would cost the country $60,000,000 (same as published for 1976), a small pittance compared with 300,000 multiplied by $27,000 over the next 18 years, equaling $8,100,000,000. This, unfortunately, spells out only the partial cost of unwanted children, since 60 percent to 80 percent of boys from indigent families on welfare will be arrested for a crime by the age of 18, and an equal percentage of girls will become pregnant by the age of 16, the latter further swelling the welfare rolls—and making necessary more schools, courts, police, fire protection, jails and, of course, additional medical facilities.

Economists are rightly asking now, "What happens when the workers, the producers, are outnumbered by the recipients, the unemployed, the aged, the invalided, the indigent?" This trend toward Robin Hoodism is already expanding too fast—it cannot last.

"Famine and mass starvation loom over Asia, Africa and Latin America where millions of people may soon breed themselves to death," to quote University of California Food Task Force scientists. Why should we willfully follow their trend?

What prompted the Hyde Amendment (which disallowed federal funds to be used for elective abortions); what was behind it? Certainly it was not an economic measure—we have shown this quite clearly. One might conclude that its acceptance was necessarily based upon moral, political or religious grounds, or a combination of these. As to the latter, those who feel strongly about the issue of never aborting a fertilized egg have this right, of course, for themselves, but for themselves only. The rights and opinions of others deserve respect, too.

Is it moral to force a poor woman to search for an inexpensive and often an ineffective abortion with its complications, or to bear an unwanted child, thus tying her to prolonged welfare? Would it not be more humane and understanding to get her on and then off welfare, providing her with safe care in the meanwhile? In most instances, as Justice of the Supreme Court Thurgood Marshall stated, "This new law will 'brutally' coerce poor women to bear children," and he was "appalled at the ethical bankruptcy of those who preach a 'right to life' that means a bare existence in utter misery for so many."

Fortunately, quite recently, during the first week of August, the Senate decreed that abortions would be permitted with federal funds to save the life of a mother, or if her health were in actual jeopardy. Had the Senate gone along with Hyde and the lower House, it would have been a death blow to the progress of medical science and to the welfare of poverty-stricken ill, a blow by a weighty crucifix molded of antiquated, religious orthodoxy in a cauldron of political high jinks. Words are not to be found that condemn strongly enough this totally unacceptable view, for life and health are our most precious possessions.

For the record, this writer is, and always has been, in favor of amply assisting those who are in dire straits, those who are in need.

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REFERENCE

1. Stengchekeris S, Gaberts S: Results of a five-year study of fetal monitoring. Obstet Gynecol 50:277, Sep 1977

The Policy Lessons Learned From RMP

TO THE EDITOR: A preliminary report, "The Lessons Learned, The Regional Medical Program (RMP) Experience,"[1] has been prepared by the Health Policy Analysis and Accountability Network, Inc. (HPAAN) of Boise—understandably they would have you pronounce it "happen." This organization seems to be attempting some kind of "cost-effectiveness" assessment of the ten-year Regional Medical Program. They only partially succeed.

Rather than actually grappling with that problem, the HPAAN survey attempted only to assess the value of the program from the standpoint of its structure and the success or failure of its function. In short, the survey was concerned with how the program worked, and what could be learned that might help in shaping future "health planning and health resources development" programs.

A practicing physician, plowing his way through the report of this "opinion survey" is puzzled by the fact that in searching for information on the value of Regional Medical Programs, HPAAN sought out the views of so few grass-roots "health care providers." Only 7.6 percent of the list of 297 respondents were in private practice. All the others were drawn from the ranks of health planners, administrators, researchers, educators, government officials. Were we, the "consumers" of these regional medical programs, too close to the project to allow proper perspective?

It was inevitable, then, that this analysis of the RMP experience would be of lesser interest to physicians and nurses than to health planners. The thrust, repeatedly emphasized, was to find "implications for future health policy." That, in itself, should make us prick up our ears and listen. What more might the health planners have in store for us?

Some of the recommendations made were moderately reassuring. HPAAN's report suggests that

> . . . the primary federal role in the development of health resources should be a role of stimulation—of providing start-up funds for demonstration projects, assisting in the education and distribution of health manpower, for example, and other kinds of support activities.

They hasten to add that this should be by no means a "federal giveaway program." The government must maintain control. Nothing new about that. If the government funds a project it reserves the right to pull the rug out from under it.

The report goes on to suggest that "regardless of the federal role in a program, the actual programming at the community level must include community involvement if the effort is to be successful." That involvement, of course, includes